

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-028970

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 162 Primary Registration District No. 559-4251 Registrar's No. 82

FILED JUL 22 1963

VS 300  
Rev. 4/59

1 0500

2 2169

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12 86-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Jefferson County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kimmswick</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>23 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Four Oaks Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>3416 Virginia Avenue</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b>		Middle <b>E.</b>	
Last <b>KAISER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/24/188</b>
9. AGE (last birthday) <b>74 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Br. Mgr.</b>	
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Henry W. Kaiser</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Muehlenbrock</b>	
14. NAME OF HUSBAND OR WIFE <b>Mrs. Rose Ellwanger Kaiser</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>	
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT Address <b>Mrs. Rose Kaiser, 3416 Virginia Ave. (18)</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <b>Cerebral arterial sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at <b>6/20/63</b> <b>4:30 P.</b>		and last saw <input checked="" type="checkbox"/> live on <b>7/12/63</b> to the best of my knowledge, from the causes stated. <b>C. E. BURNSIDE, M.D.</b> <b>206 West Argonne</b> <b>St. Louis 22, Missouri</b>	
22a. SIGNATURE (Degree or title) <b>Charles Burnside M.D.</b>		22b. ADDRESS <b>206 West Argonne</b> <b>St. Louis 22, Missouri</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>		22d. LOCATION (City, town, or county) <b>St. Louis County, Missouri.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>July 15, 1963</b>	
24. FUNERAL DIRECTOR <b>Beiderwieden Funeral Home, 3620 Chippewa</b>		25. DATE RECD. BY LOCAL REG <b>7-15-63</b>	
26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		27. DATE SIGNED <b>7/13/63</b>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

JUL 23 1963

TA 1-5798

Dr. Charles Burman  
206 W. Angeline

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Thomas H. Fritz

Licensed Embalmer No. 3882

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.